Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JT DILGER JR, MD
6718 MONTAY BAY DRIVE
SPRING, TX 77389

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3314-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Exam filed via fax on 7/19/2010 DDE RTWDDE"

Amount in Dispute: $1,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on June 03, 2011 with no response to MFDR

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2010	99456-WP-W5 and 99456-RE-W8	$1,600.00	$1,450.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   No Explanation of Benefits was provided by either party to the dispute.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed the amount of $1,100.00 for CPT code 99456-WP-W5 for Division ordered DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR) and Return to Work (RTW) status. Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Documentation also supports an examination for assignment of an IR on the non-musculoskeletal central nervous system per 28 Texas Administrative Code §134.204(j)(4)(D)(iv) & (v) the MAR for the IR using the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition with a MAR of $150.00. Documentation also supports the rating of the right shoulder (upper extremities) with the Range of Motion (ROM) IR method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and a MAR of $300.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category I method on the cervicothoracic (spinal region) is $150.00. There also was a ROM examination for assignment of an IR on the musculoskeletal hip but per 28 Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis/hip are part of one body area, the spine. There is no separate spinal area reimbursement apart from the amount recommended for the cervicothoracic area. The combined MMI/IR MAR is $950.00. Documentation also supports the billing of CPT code 99456-RE-W8 for RTW status examination per 28 Texas Administrative Code §134.204(i)(1)(E). Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the MAR for the 1st examination is $500.00.
2. Respondent has not paid any amount on CPT code 99456-WP-W5 or 99456-RE-W8, therefore $1,450.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,450.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,450.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.